Elgin Foot & Ankle Center *Providing Quality Foot and Ankle Care*

Available 24/7, 365 days/year

Please Print and Use Black Pen

Name:_____ Nickname/Preferred Name :_____

Birth date: _____ Gender: M F E-mail address: _____

Address:_____City:_____State:_____Zip: _____

Home phone:_____ Work phone: _____ Cell phone: _____

E-mail address: _____

Marital Status: single married divorced widowed separated *Circle if:* Full time student Part time student

Employer name:_____

If patient has a legal Power of Attorney or is a minor, please give POA/guardian/parent names and relation to patient:

_____

List any family members or other people you would like for us to share your medical information with:

_____

PERSON RESPONSIBLE FOR PAYMENT, IF NOT PATIENT

If patient is a minor, please enter responsible party information.
(The adult presenting the minor for care is the responsible party. We cannot bill absent parents.)

Name:_____**Birth date**: _____

Address:_____City:_____State:_____Zip: _____

Home phone:_____ Gender: M F Marital Status: single married divorced widowed separated

Employer name:_____Work phone:_____Occupation:_____

Relationship to patient: _____

INSURANCE INFORMATION (PLEASE SHOW US YOUR INURANCE CARDS)

Primary Insurance Company Name:_____

Insured Name:_____ **Date of Birth**:_____

Gender: M F Relationship to patient_____

Secondary Insurance Company Name:_____

Insured Name:_____ **Date of Birth**:_____

Gender: M F Relationship to patient_____

How did you hear about our practice? ___insurance ___our website ___internet ___facebook ___Walgreens

___hospital ___emergency room

___physician (name) _____ ___friend/relative (name)_____

___other _____

Primary Care Physician:_____ **Phone**:_____

Referring Physician:_____ **Phone**:_____

Pharmacy:_____ **Phone**:_____

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/_____

TREATMENT CONSENT

I hereby authorize and consent to treatment at Elgin Foot & Ankle Center, S.C. This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis or treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to Elgin Foot & Ankle Center, S.C. for any services rendered by the practice subsequent to this date, and for such other charges as may be made by said practice. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that health insurance coverage varies and that not all services provided may be covered. It is my responsibility to negotiate payments from the insurance company and while they use such terms as customary, reasonable, prevailing, usually, etc. to limit their coverage, **payment of the charges remain my obligation.**

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. I agree to pay for service rendered, in full at time of service, unless other arrangements are made in advance with this office. Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services which may not be available at the time of leaving the office. I agree to pay for any attorney fees or collection fees that result of the pursuit of collection for services rendered.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Elgin Foot & Ankle Center, S.C. to release any and all information to insurance companies or associations, employee groups, employer, government agencies or their third party payers and their agents or employees, either by mail or electronically, as may be necessary for the completion of all my claims or government/insurance compliance or coordination of care. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records.

AUTHORIZATION TO LEAVE MESSAGES

I authorize the staff of Elgin Foot & Ankle Center, S.C. to leave a message on my home or cell voice mail, answering machine or other electronic device, or with a person who answers my home or cell phone in regards to my health, my appointment, or my financial obligations to the practice.

TRANSFER OF CREDIT BALANCE

A credit balance resulting from payment to Elgin Foot & Ankle Center, S.C. from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

I certify that the information provided on the front of this form is correct to the best of my knowledge. I have read and understand the above and duly authorize Elgin Foot & Ankle Center, S.C. and/or its appointees to execute the above and its terms.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE